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PRENATAL HEALTH CARE: TODAY'S SOLUTION TO THE FUTURE'S LOSS

L. RACHEL EISENSTEIN

THE United States of America prides itself on being a country concerned with the welfare of its citizenry. Why then is the United States ranked behind nineteen other industrialized nations in the number of babies dying before their first birthdays?¹ Why is a non-white infant born in the United States today twice as likely as a white child to die within the first year of life?² In fact, why is the infant mortality rate for black infants in some United States cities³ worse than the rates in some Third World countries?⁴

The infant mortality rate indicates the number of babies born alive but dying before they reach their first birthday.⁵ A major contributing factor to infant death and disability is low birthweight, which is identified as under five and one half pounds.⁶ Low birthweight babies are forty times more likely to die during their first month of life.⁷ If these

1. NATIONAL COMMISSION TO PREVENT INFANT MORTALITY, *TROUBLING TRENDS: THE HEALTH OF AMERICA'S NEXT GENERATION* 2 (Feb. 1990) [hereinafter *TROUBLING TRENDS*]. The National Commission to Prevent Infant Mortality was formed by Congress in 1986 to create a national strategic plan to reduce infant mortality and morbidity in the United States. The sixteen-member Commission includes Members of Congress, the Secretary of Health and Human Services, the Comptroller General of the United States, representatives of state government and experts in the field of maternal and child health. For more specific information, write the National Commission to Prevent Infant Mortality, Switzer Building Room 2014, 330 C. Street, S.W., Washington, D.C. 20201.

This Article is presented as a summary of recent studies conducted by the National Commission to Prevent Infant Mortality, the Florida Healthy Mothers, Healthy Babies Coalition, and the Alan Guttmacher Institute. The citations are to reports which have been compiled by these entities. For more specific information, addresses are provided within the citations.

2. NATIONAL COMMISSION TO PREVENT INFANT MORTALITY, *DEATH BEFORE LIFE: THE TRAGEDY OF INFANT MORTALITY* 8 (Aug. 1988) [hereinafter *DEATH BEFORE LIFE*]. For more information about the National Commission to Prevent Infant Mortality, see *supra* note 1. As of 1987, Florida non-white infants were dying at a rate of 18.2 per 1000 while white infants were dying at a rate of 7.9 per 1000. FLORIDA DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES, *FLORIDA PUBLIC HEALTH PLAN* 8 (1990). [hereinafter *FLORIDA PUBLIC HEALTH PLAN*].

3. For example, cities such as Washington, D.C., Detroit, and Philadelphia have infant mortality rates which are twice the national average and higher than Jamaica or Costa Rica. *TROUBLING TRENDS*, *supra* note 1, at 2.

4. NATIONAL COMMISSION TO PREVENT INFANT MORTALITY, *INFANT MORTALITY: CARE FOR OUR CHILDREN, CARE FOR OUR FUTURE* 4 (Jan. 1988) [hereinafter *INFANT MORTALITY*]. For more information about the National Commission to Prevent Infant Mortality, see *supra* note 1.

5. *Id.* at 2.

6. *TROUBLING TRENDS*, *supra* note 1, at 3.

7. *Id.*

tiny babies do survive, they are two to three times more likely to suffer from chronic handicapping conditions like blindness, deafness, and mental retardation.⁸

These statistics indicate that the most effective way to prevent infant mortality is to reduce the number of babies born at low birthweight. The easiest and most cost-effective way of lowering the incidence of low birthweight is making sure each and every woman receives adequate prenatal health care.⁹

Prenatal health care is defined as "pregnancy- and infant-related medical and support services provided with the goal of promoting the health and well-being of the pregnant woman, the fetus, the infant, and the family up to one year after the infant's birth."¹⁰ Prenatal care is composed of three basic parts: 1) early and continuing risk assessment; 2) health promotion; and 3) medical and psychosocial interventions and follow-up.¹¹

This Article will concentrate on identifying high-risk mothers and their babies, describing the problems mothers have in obtaining prenatal care, and targeting intervention strategies needed to reduce the rate of infant mortality. The Article will also describe various projects in Florida presently being implemented at the county level as well as the role of the private sector in assuring an improved system of insurance coverage. Finally, this Article will outline courses of action suggested by the National Commission to Prevent Infant Mortality.

I. FRUSTRATING STAGNATION IN THE IMPROVEMENT OF INFANT MORTALITY RATES

In 1987 3.8 million infants were born in the United States. Of these, 39,000 died before reaching their first birthdays, amounting to an infant mortality rate of 10.1 infant deaths per one thousand live births.¹² Although the United States' infant mortality rate has steadily decreased since the late 1960's, improvements in the rate have virtually stopped since 1982.¹³

8. *Id.*

9. In 1986, Florida ranked 48th in the country in providing prenatal care, with only 67.9% of pregnant women receiving care in their first trimester, compared with 76.2% in the United States overall. *FLORIDA PUBLIC HEALTH PLAN*, *supra* note 2, at 7 (1990).

10. *TROUBLING TRENDS*, *supra* note 1, at 28.

11. *Id.*

12. *Id.* at 9. In 1985, Florida's infant mortality rate was 11.3 infant deaths per 1000 live births. *INFANT MORTALITY*, *supra* note 4, at 3.

13. *INFANT MORTALITY*, *supra* note 4, at 2. Between 1970 and 1980, the infant mortality rate in the United States declined by almost 40%—from 20.0 to 12.6 deaths per 1000 live births—even though the percentage of low birthweight births declined only 1.1%—from 7.9% to 6.8%. The 1980's showed an actual increase in the percentage of infants born at low birthweight from 6.8% in 1980 to 6.9% in 1987. *TROUBLING TRENDS*, *supra* note 1, at 14.

In order to understand why improvements in the infant mortality rate have halted, it is necessary to examine the causes of infant death. When a baby dies within the first twenty-eight days of its life, it is usually due to circumstances surrounding the pregnancy and birth. For example, low birthweight, poor maternal nutrition, lack of access to prenatal health services, and congenital defects may all cause a baby to die within the first month of its life. On the other hand, when a baby dies between twenty-eight days and one year of age, its death can usually be associated with the infant's environment such as poverty, lack of access to pediatric care, poor nutrition, poor sanitation, or inadequate supervision.¹⁴

Unfortunately, the drop in the infant mortality rate from the 1960's to the present has not been accompanied by a similar reduction in babies born at low birthweight.¹⁵ Thus, the reduction in the infant mortality rate can be attributed to the ability of medical technology to save smaller and smaller babies rather than improvements in access to prenatal health care.¹⁶ However, the wonders of medical technology and the ability of physicians to save low birthweight newborns are quickly reaching their limits. Limited medical technology combined with a steady low birthweight rate in the United States have recently caused the infant mortality rate to level off.¹⁷

II. HIGH-RISK MOTHERS HAVING BABIES

In assessing risk, one must examine both the medical risks of women and children and the social risks of women. A child is classified as a medical risk if, among other things, he or she is born premature or at a low birthweight; has a chronic disease such as asthma; has a life-threatening condition such as Sudden Infant Death Syndrome (SIDS) or a breathing problem; has a congenital defect such as Down's syndrome; or is born affected by drugs or alcohol.¹⁸ A pregnant woman might be classified as a medical risk if she has previously had a low birthweight baby or is hypertensive, diabetic, or malnourished. A woman is a social risk, on the other hand, if she is poor,

14. TROUBLING TRENDS, *supra* note 1, at 9-10.

15. See *supra* note 13.

16. INFANT MORTALITY, *supra* note 4, at 2. It is also significant that neonatal medicine costs the United States more than \$2.5 billion each year, often leaving the tiny survivors with persistent physical and learning disabilities. TROUBLING TRENDS, *supra* note 1, at 14-15.

17. INFANT MORTALITY, *supra* note 4, at 2.

18. NATIONAL COMMISSION TO PREVENT INFANT MORTALITY, HOME VISITING: OPENING DOORS FOR AMERICA'S PREGNANT WOMEN AND CHILDREN 14 (July 1989). For more information about the National Commission to Prevent Infant Mortality, see *supra* note 1.

young, unmarried, a minority, homeless, unemployed, or emotionally or physically abused.¹⁹

The risk factors associated with low birthweight might include both medical and social risks like teenage pregnancy, poverty, low levels of education, a high number of previous births, inadequate prenatal care, poor nutrition, smoking, and substance abuse. Since infant mortality is one of the most useful indicators of the health of a society,²⁰ these factors must be reduced if we are to decrease the infant mortality rate in this country and increase our future productivity.

As discussed above, minority women who are poor, young, or under-educated, who fail to get early prenatal care, or whose pregnancies are unintended, are at the highest social risk of having low birthweight babies. In addition, increases during the 1980's in the use of "crack" cocaine, in the incidences of Acquired Immune Deficiency Syndrome (AIDS) and syphilis, and in births to unmarried mothers have also contributed to infant mortality.²¹ In order to reduce low birthweight and infant mortality rates in the United States, we must reduce the risks that put the health of mothers and children in jeopardy.

The problem of crack-addicted pregnant women has been worsening, with serious consequences befalling the unborn child.²² Cocaine and other drugs, including alcohol, readily pass from the mother's bloodstream into the fetal bloodstream. It follows that when the infants are born, they are at a much higher risk for low birthweight and congenital defects. Cocaine-addicted women also have higher rates of miscarriage and premature onset of labor.²³

The infants born to women using cocaine often experience painful withdrawal from cocaine at birth. They may even suffer prenatal strokes before birth because of the fluctuations in blood pressure caused by cocaine. Children of cocaine-addicted women also experience a higher than normal rate of kidney and breathing disorders, and a greater risk of SIDS. Finally, these children have increased visual and coordination problems, and a higher incidence of mental retardation.²⁴

19. *Id.*

20. INFANT MORTALITY, *supra* note 4, at 2.

21. TROUBLING TRENDS, *supra* note 1, at 21.

22. From March 1987 to 1988, 2000 neonatal cocaine cases were identified in Miami alone. FLORIDA PUBLIC HEALTH PLAN, *supra* note 2, at 8.

23. TROUBLING TRENDS, *supra* note 1, at 21.

24. FLORIDA HEALTHY MOTHERS, HEALTHY BABIES COALITION, ALCOHOL AND OTHER DRUGS CAN HARM AN UNBORN BABY 2 (1989) [hereinafter ALCOHOL & DRUGS]. The Florida Healthy Mothers, Healthy Babies Coalition brings together organizations and individuals who share a

Marijuana is another drug that adversely affects a pregnant woman's unborn child. Women who smoke marijuana are more likely to have stillborn babies, and have a higher rate of miscarriages, low birthweight babies, and fetal abnormalities, especially of the nervous system. The active ingredient in marijuana, THC, passes through the placenta potentially causing the baby to be born "high."²⁵

Alcohol intake, especially in the early months of pregnancy, can also be very dangerous to a developing baby. Alcohol freely passes into the baby's bloodstream and affects the developing systems. Since there is no established safe level of alcohol intake, the Surgeon General advises pregnant women to completely abstain from drinking alcoholic beverages and to be aware of the alcoholic content of foods and drugs.²⁶ Findings show that drinking only one ounce of absolute alcohol per day may cause a sizeable decrease in birthweight. In addition, there have been significant increases in spontaneous abortions by women drinking only one ounce of absolute alcohol twice a week.²⁷

Perhaps the saddest result of maternal alcohol consumption is the birth of a child with Fetal Alcohol Syndrome (FAS).²⁸ FAS is the leading cause of mental retardation in this country, and, of the top three, is the only preventable cause.²⁹ FAS may also be characterized by central nervous system disorders, growth deficiencies, facial abnormalities, and skeletal, urogenital, and cardiac malformations.³⁰

Finally, research has shown that even smoking cigarettes or drinking too much caffeine can be risky for a developing baby. In addition to doubling the chances that a child will be born weighing less than 5.2 pounds, maternal smoking has been associated with miscarriage, preterm birth, SIDS, and respiratory distress syndrome. Passive

concern for the health of the 150,000 infants born in Florida each year.

The Coalition was created in 1984 under the sponsorship of the March of Dimes Birth Defect Foundation, the University of Florida's Department of Obstetrics and Gynecology, and the Florida Department of Health and Rehabilitative Services. For more specific information, write The Florida Healthy Mothers, Healthy Babies Coalition, 730 N.E. Waldo Road, Suite B, Gainesville, FL 32601.

25. *Id.*

26. *Surgeon General's Advisory on Alcohol and Pregnancy*, 11 FDA DRUG BULLETIN 2 (July 1981) [hereinafter DRUG BULLETIN].

27. *Id.*

28. In 1983, there were an estimated 2400 babies born with FAS in the United States. FLORIDA PUBLIC HEALTH PLAN, *supra* note 2, at 8.

29. NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE, NCADD FACT SHEET: ALCOHOL-RELATED BIRTH DEFECTS 1 (Jan. 1990) [hereinafter NCADD FACT SHEET]. FAS ranks ahead of Down's Syndrome and *spina bifida*. Berman, *Concerns in Pregnancy*, LAMAZE PARENT'S MAG., Feb. 1989, at 28.

30. DRUG BULLETIN, *supra* note 26, at 1. Fetal alcohol effects (FAE), a less severe version of FAS, is characterized by milder or less frequent FAS signs. NCADD FACT SHEET, *supra* note 29, at 1.

smoking can also be dangerous for pregnant women, resulting in an increased risk of low birthweight babies. While conflicting results have been reached regarding the effect of caffeine on an unborn child, there is enough uncertainty in research results to warrant pregnant women limiting or avoiding caffeine intake.³¹

Adolescent pregnancy is another risk factor which may contribute to infants being born with serious problems. Each year, approximately 470,000 babies are born to teenage women.³² Between 1973 and 1987 one out of every ten babies born in Florida was born to a teenager.³³ This statistic not only impacts the health of the mother and child but also jeopardizes both of their educations, economic futures, and family relationships. The majority of teenage parents never receive a high school diploma, resulting in lower family incomes. This, in turn, accounts for the fact that one half of the cost of Aid to Families with Dependent Children (AFDC) is due to families in which the woman was a teenage parent.³⁴ Moreover, teen parents who marry are three times more likely to separate and divorce.³⁵

Births to women under the age of sixteen also present higher medical risks to both mother and child. These women are significantly more likely to have infants who are born with low birthweights and, therefore, have an increased risk of dying or incurring long term health problems.³⁶ Nationally, pregnant teens are the least likely of any age group to receive early and continuous prenatal care.³⁷ Because teenagers are the least likely to receive prenatal care, their chances of having problems are greater than for pregnant women in their twenties or thirties. There is evidence that if teenagers received the prenatal care they need, their rates of low birthweight and infant mortality would be comparable to those of older mothers.³⁸

III. USING PRENATAL CARE TO PREVENT LOW BIRTHWEIGHT

Low birthweight infants are the major reason for the United States' high infant mortality rate. The obvious solution to this problem is to

31. Berman, *supra* note 29, at 27-28.

32. TROUBLING TRENDS, *supra* note 1, at 23.

33. FLORIDA HEALTHY MOTHERS, HEALTHY BABIES COALITION, A FIVE YEAR REPORT 13 (Apr. 1989). For more information about the Florida Healthy Mothers, Healthy Babies Coalition, see *supra* note 24.

34. *Id.*

35. FLORIDA HEALTHY MOTHERS, HEALTHY BABIES COALITION, PREGNANCY OUTCOMES IN FLORIDA: 1983-1987 12 (Oct. 1988). For more information about the Florida Healthy Mothers, Healthy Babies Coalition, see *supra* note 24.

36. *Id.*

37. In Florida, 16.6% of adolescent mothers receive late or no prenatal care, compared with 11.7% in the United States as a whole. FLORIDA PUBLIC HEALTH PLAN, *supra* note 2, at 7.

38. TROUBLING TRENDS, *supra* note 1, at 23.

reduce the incidence of low-birthweight babies. Experts generally agree that the best way to prevent low birthweight is to start prenatal care early in the pregnancy.³⁹ All pregnant women should make their first visit to the obstetrician within the first three months of pregnancy. In addition, visits throughout pregnancy should continue in order to monitor progress. The American College of Obstetricians and Gynecologists (ACOG) recommends that care begin within the first month of pregnancy and that a total of thirteen visits be made thereafter.⁴⁰

Even with the quality of medical care and technology available in the United States, however, twenty-four percent of births are to women who make fewer than nine prenatal visits.⁴¹ The percentage getting insufficient care is highest among the unmarried, teenagers, the least educated, Blacks, Hispanics, and the poor. Geographically, the South has the highest proportion of women that do not seek the recommended prenatal care. In Florida 27.3% of women make too few visits to the doctor during pregnancy, while three percent of women get no prenatal care.⁴²

Overall, the most common health problems which require neonatal intensive care are caused by complications experienced during labor or delivery, such as breech births and umbilical cord complications. Low birthweight is a problem faced by seven percent of all babies.⁴³ Low birthweight babies are more likely to need expensive neonatal intensive care and intermediate or sick baby nursery care. In addition, a low birthweight baby who survives has a greater chance of having a mental or physical handicap, thus requiring a lifetime of costly care. Neonatal intensive care costs may range from \$20,000 to \$100,000 per infant. Moreover, a lifetime of health and custodial care for a handicapped child may be as high as \$300,000 to \$400,000 per child.⁴⁴

The Institute of Medicine estimates that for every one dollar spent on prenatal care, \$3.38 in later costs is saved. In addition, the cost of

39. 1 THE ALAN GUTTMACHER INSTITUTE, *PRENATAL CARE IN THE UNITED STATES: A STATE AND COUNTY INVENTORY* 5 (1989) [hereinafter *PRENATAL CARE VOL. 1*] The Alan Guttmacher Institute is an independent, non-profit corporation for research, policy analysis and public education. For more information, write The Alan Guttmacher Institute, 111 Fifth Avenue, New York, NY 10003, or 2010 Massachusetts Avenue, N.W., Washington, D.C. 20036.

40. *Id.*

41. *PRENATAL CARE VOL. 1*, *supra* note 39, at 7.

42. *Id.* at 9. Nationally, two percent of all women giving birth get no prenatal care. *Id.*

43. THE ALAN GUTTMACHER INSTITUTE, *BLESSED EVENTS AND THE BOTTOM LINE: FINANCING MATERNITY CARE IN THE UNITED STATES* 12 (1987) [hereinafter *BLESSED EVENTS*]. For more information concerning the Alan Guttmacher Institute, see *supra* note 39.

44. *INFANT MORTALITY*, *supra* note 4, at 6.

prenatal care, excluding labor and delivery, has been estimated at \$400 per pregnancy and \$600 for preventive care during an infant's first year of life.⁴⁵ Thus, the cost-effectiveness of prenatal and preventive care is impressive when one compares these costs to the costs resulting from caring for a sick or handicapped child over its lifetime. As a result, targeting mothers who are at risk for low birthweight babies is less expensive and, therefore, more cost-effective than sustaining an infant through the use of medical technology.

IV. ACCESS BARRIERS TO PRENATAL CARE

Why are so many women not receiving prenatal health care that is not only cost-effective, but is also linked to declines in rates of maternal and infant mortality? There are numerous barriers, including a lack of insurance coverage, limitations in the Medicaid program, inadequate system capacity, inhospitable conditions at local health care sites, and a lack of coordination of available services. A woman also is faced with individual barriers such as her beliefs, lifestyle, knowledge, or attitude about prenatal care.⁴⁶

A. *Economic and Human Losses to Society*

The costs to society of sick and dying babies is enormous not only in economic terms but also in human terms. While the human costs of suffering and feelings of loss at the death of one's child are immeasurable, the economic costs are measurable and involve both direct health care and supportive costs plus indirect costs. The direct costs have been discussed above.⁴⁷ The indirect costs, on the other hand, are the lost productivity and foregone wages of these individuals who never have the chance to enrich our society by living up to their full potential. In addition, disabled youngsters may cause their parents to be less productive on the job because of the time necessary to care for a disabled child.⁴⁸

45. *Id.*

46. Address by Senator Lawton Chiles, Chair of the National Commission to Prevent Infant Mortality, Brookings Institute Conference on Improving Access to Health Services for Pregnant Women and Children (July 17, 1989).

47. See *supra* text accompanying note 44.

48. NATIONAL COMMISSION TO PREVENT INFANT MORTALITY, 1985 INDIRECT COSTS OF INFANT MORTALITY AND LOW BIRTHWEIGHT 1 (May 1988). For more information about the National Commission to Prevent Infant Mortality, see *supra* note 1. If the 40,030 babies who died in 1985 had lived to become productive members of society, the current value of their future earnings would have been between \$10.2 and \$18.9 billion. Similarly, if the United States could reduce its number of disabled low birthweight babies by one half, the present value of wages that children spared these disabilities could earn would be between \$0.9 billion and \$1.9 billion and between \$0.2 billion and \$0.3 billion for their parents. *Id.*

B. Paying for Prenatal Health Care

Maternity and neonatal care is primarily financed through private health insurance. In addition, many women are dependent on federal and state assistance programs like AFDC and Medicaid, as well as other state-sponsored assistance programs. For working women, employers are the primary source of health care coverage.⁴⁹

The number of women with no health coverage is startling—an estimated thirty-five to thirty-seven million people in the United States lack health coverage completely. These people, who do not qualify for public assistance and lack private health insurance, are often referred to as the “working poor.”⁵⁰

1. Medicaid Availability

Medicaid is the federal-state program designed to finance health care for the poorest members of our society. Originally, Medicaid targeted only certain groups, primarily AFDC and Supplemental Security Income (SSI) recipients.⁵¹ The Medicaid program is financed jointly by the federal government and the states but is administered solely by the states. The extent of coverage, eligibility criteria, services covered, and reimbursement levels, therefore, vary widely from state to state.

Congress took a significant step toward providing access to Medicaid when it passed the Omnibus Budget Reconciliation Act of 1986 (OBRA-86).⁵² This law allows states to raise Medicaid income eligibility thresholds for pregnant women and their children as high as the federal poverty level. The passage of this Act was especially significant given the decade-long erosion of income eligibility thresholds under the AFDC program which, between 1975 and January 1988, fell from 72.8% to 48.8% of the federal poverty level.⁵³ Unfortunately, many poor women still do not qualify for Medicaid.

In the 1990 Regular Session of the Florida Legislature, House Bill 1209, along with the general appropriations bill, expanded Medicaid coverage to children.⁵⁴ Changes include mandatory coverage of chil-

49. INFANT MORTALITY, *supra* note 4, at 7.

50. *Id.*

51. In 1984, AFDC and SSI recipients accounted for 77% of the Medicaid population. FLORIDA HEALTHY MOTHERS, HEALTHY BABIES COALITION, IMPROVING PREGNANCY OUTCOMES IN FLORIDA 1988 4 (Oct. 1988) [hereinafter IMPROVING PREGNANCY]. For more information about the Florida Healthy Mothers, Healthy Babies Coalition, see *supra* note 24.

52. Pub. L. 99-509, 100 Stat. 1874 (1986).

53. I. HILL, REACHING WOMEN WHO NEED PRENATAL CARE 1 (1988) (available from the National Governor's Association).

54. Ch. 90-295, § 17, 1990 Fla. Laws 2342 (codified at FLA. STAT. § 409.266).

dren who are over one year of age and under six years of age, with family incomes below 133 1/3% of the federal poverty level,⁵⁵ adequate payment of obstetrical and pediatric services, and coverage for treatment to correct physical or mental problems identified during screenings, even if those follow-up services are not covered under the State's Medicaid plan.⁵⁶ Many states have expanded Medicaid eligibility for pregnant women and children with family incomes up to 185% of the federal poverty level. Unfortunately, this 185% allowed maximum was not funded in Florida.

Because the process of applying for Medicaid is long and complicated, many qualifying women feel intimidated and may not attempt to get the assistance they so badly need. Difficulties in applying include inconvenient location of eligibility intake offices, the stigma of being on welfare, complex application forms requiring extensive verification of items like income and third-party liability, and slow or delayed turnaround time for processing the application.⁵⁷ Congressional and state efforts have focused on removing these bureaucratic barriers which deter women from seeking prenatal care.

OBRA-86 has a Presumptive Eligibility option which permits states to provide immediate, short-term eligibility that includes Medicaid-reimbursed prenatal care to pregnant women waiting for their formal Medicaid applications to be approved. This option addresses three critical shortcomings of the eligibility process: 1) it improves access by moving the initial eligibility intake point to the provider site, where more needy women are likely to seek assistance; 2) it simplifies the application process by reducing the means-test to a preliminary review of income only; and 3) it provides immediate coverage of prenatal care by insuring women on a same-day basis for a limited period of time while also guaranteeing reimbursement to their providers.⁵⁸ Florida is one of seven states who have adopted and implemented a presumptive eligibility program.⁵⁹

In Florida, state funding is insufficient in many ways to support adequately comprehensive maternity services. Therefore, local funding is needed to supplement state and federal initiatives. Expanded reimbursements for maternity care providers have not significantly in-

55. *Id.* (codified at Fla. Stat. § 409.266(7)(g)). In 1990, the federal poverty level was \$13,380 for a family of three. TROUBLING TRENDS, *supra* note 1, at 30.

56. Killian, *Lawyers' Legislative Efforts Pay Off For Children*, The Florida Bar News, July 1, 1990, at 8.

57. I. HILL, *supra* note 53, at 9.

58. *Id.* at 15.

59. The other states are Arkansas, Maryland, Massachusetts, North Carolina, Pennsylvania, and Utah. *Id.* at 16.

creased private sector participation, and the process for determining Medicaid eligibility is still cumbersome and time-consuming for patients. Health department personnel are responsible for handling presumptive eligibility,⁶⁰ but a different state office, the Department of Social and Economic Services, completes the final certification process.⁶¹ Also, patients must undergo screenings for other programs, like AFDC and Food Stamps, before they can be certified for coverage under OBRA-86. Finally, there is a problem with patients following through with the process in many counties. Statewide, only about sixty-five percent of the presumptively-eligible population ultimately is certified under Medicaid. Thus, problems exist even when such a program is in place.⁶²

As many states expand Medicaid coverage to additional low-income pregnant women and children, fewer obstetricians and family physicians are willing to deliver the care. Health care providers are also shying away from Medicaid patients because of the increase in the paperwork burden of physicians who are responsible for obtaining, completing, and filing the forms; the months-long wait for monetary reimbursement;⁶³ and finally, the fear of malpractice suits by Medicaid patients, who tend to be at higher risks for adverse outcomes.⁶⁴ Another disincentive to providers is the fact that states sometimes stop payments completely if funds are depleted before the end of the fiscal year.

2. Publicly Funded Clinics

Poor women depend heavily on publicly funded clinics to obtain prenatal care. Many of these clinics are operated by health departments, hospital outpatient facilities, and community and migrant health centers.⁶⁵ Under the Maternal and Child Health (MCH) program, federal funds are made available to states in order to provide

60. IMPROVING PREGNANCY, *supra* note 51, at 6.

61. *Id.*

62. *Id.*

63. Florida limits the total payment for prenatal care alone to \$62.50. This is less than 1/10 of the average physicians' charge for prenatal care. BLESSED EVENTS, *supra* note 43, at 34.

64. *Id.* There is a widely held perception that poor people sue more often than others. While empirical information on this topic is very limited, many physicians tend to have this perception and refuse low income patients. NATIONAL COMMISSION TO PREVENT INFANT MORTALITY, MALPRACTICE AND LIABILITY: AN OBSTETRICAL CRISIS 10 (Jan. 1988). For more information about the National Commission to Prevent Infant Mortality, see *supra* note 1.

65. Sixty percent of women on Medicaid and 39% of women with family incomes below the federal poverty standard obtain their prenatal care at a clinic, compared with only 21% of all women. BLESSED EVENTS, *supra* note 43, at 36.

health care to poor pregnant women and children.⁶⁶ The MCH block grant is administered by the MCH divisions of individual state agencies. Within broad parameters established by Congress,⁶⁷ states determine the type and scope of services offered under the grant and how the services will be delivered. Services offered will usually include maternity and infant care, high-risk pregnancy programs, support for neonatal intensive care units, pediatric health services, services for children with special health care needs, and family planning.⁶⁸

In fiscal year 1989 total federal MCH block grant funding was \$554 million.⁶⁹ For every four dollars of federal block grant monies, states must match three dollars of their own. Thirty-four states supplement the match with other funds for prenatal or delivery services.⁷⁰ In 1986, an estimated 447,000 women received MCH-supported prenatal health care services in all but four states.⁷¹ While most of these grants go to health departments and hospitals, some states supply funding to other agencies, such as community health centers.⁷²

Community health centers and migrant health centers are two other federally funded programs.⁷³ These public or private not-for-profit organizations offer a broad range of primary health care services to people living in medically underserved areas and to migrants or seasonal workers and their families. These programs have no state matching requirements, and funds go directly from the federal government to the health centers.⁷⁴ Many states work with local centers to assess needs and plan for primary health care services. States also provide technical assistance and aid in designating areas to be categorized as medically underserved.⁷⁵ In addition, the centers may receive monies from other sources, bill Medicaid or private insurers, and charge patients for services based on their ability to pay. The centers may not, however, turn patients away based on their inability to pay.⁷⁶

There is a community or migrant health center or MCH provider in every state except Wyoming, but these clinics may not be available in

66. 42 U.S.C. § 705 (1988).

67. *Id.*

68. PRENATAL CARE VOL. 1, *supra* note 39, at 50.

69. *Id.*

70. *Id.*

71. The four states not using MCH funds to support prenatal services are Alaska, Montana, North Dakota, and Wyoming. *Id.*

72. *Id.*

73. 42 U.S.C. §§ 254b, 254c (1988). There are approximately 560 community and migrant health centers presently in the United States. BLESSED EVENTS, *supra* note 43, at 36.

74. In fiscal year 1989, \$415 million was appropriated for CHC's and \$46 million for MHC's. PRENATAL CARE VOL. 1, *supra* note 39, at 50.

75. *Id.*

76. *Id.*

all areas of need. For example, as already mentioned, MCH programs in four states provide no prenatal care. In Louisiana and Virginia the MCH programs will not serve women at high risk for adverse birth outcomes. Conversely, in Hawaii, Idaho, Minnesota, and South Dakota the MCH programs serve only high-risk women. Fifteen percent of all community and migrant health centers offer no prenatal care. Another thirty-four percent that do provide prenatal care will not serve patients at high risk of adverse outcomes, undoubtedly because of the high cost of obtaining malpractice insurance.⁷⁷

3. *The WIC Program*

One other federally funded program is the Special Supplemental Food Program for Women, Infants, and Children (WIC).⁷⁸ The WIC program provides supplemental food, education, and health care referrals to eligible low income women who are pregnant, breastfeeding, or new mothers, as well as to infants and children up to age five.⁷⁹ WIC is operated by the Department of Agriculture, through its Food and Nutrition Service. Fiscal year 1989 appropriations for WIC were \$1.9 billion. These funds go to state health departments, which, in turn, give grants to local public and private health and social service agencies such as health departments, community-based health clinics, hospitals, and community action agencies. While states are not required to match these federal funds, some states supplement the federal WIC money with additional monies for WIC services.⁸⁰

In order to qualify for WIC, women must not only meet an income eligibility requirement,⁸¹ they must also be at nutritional risk. The Department of Agriculture has established guidelines for nutritional risk assessments, but states have considerable leeway in actually defining which nutritional risks are covered.⁸²

Women and children who are in the WIC program receive checks or vouchers which enable them to purchase a monthly food package designed to supplement their diets with foods high in protein and vitamins. These foods may be delivered to a woman's home or she may be required to pick up the food at a warehouse. Eighty percent of the appropriated funds are earmarked for food, while the remaining

77. BLESSED EVENTS, *supra* note 43, at 36, 40.

78. 42 U.S.C. § 1786 (1988).

79. PRENATAL CARE VOL. 1, *supra* note 39, at 51.

80. *Id.*

81. States may set income eligibility standards at 100% to 185% of the federal poverty level. In practice, most have opted for 185%. *Id.*

82. Factors indicating nutritional risk include anemia, abnormal weight gain during pregnancy, a history of high-risk pregnancies, low birthweight, and stunted growth. *Id.*

twenty percent go for nutrition services, including counseling and program administration.⁸³

C. Private Health Insurance: What Can the Private Sector Do?

Contrary to popular belief, having a job or a spouse with a job does not guarantee a family access to health insurance that will cover the family's maternity and pediatric needs. Because about 9.5 million women have no public or private health insurance, insurance deficiencies are especially serious for women's health care needs.⁸⁴ Lack of insurance coverage adversely affects the number of women receiving basic health care services, including maternity and prenatal health care. Women who lack an employee health insurance plan may earn above the Medicaid maximum, so they fall through the cracks of our patchwork system of health care financing.

Private sector employers can help plug these cracks, but why should corporate executives be concerned with improving infant and maternal health? While the birth of a child may seem unrelated to the boardroom, the two, in fact, are inextricably bound. The policies made in the boardroom can influence the health of newborns which, in turn, may impact the future of America's businesses and overall productivity.⁸⁵

Demographic changes are forcing businesses to become more aware of the health insurance coverage offered to their employees. First, today's workplace is much different than in the past. The traditional nuclear family, with a father who works and a mother who stays home to care for the children, is quickly becoming a thing of the past. In fact, in 1987 only 3.7% of American families fit this description.⁸⁶ In addition, after conducting a recent study, the United States Department of Labor predicts that between now and the turn of the century, women will constitute nearly two-thirds of the new entrants into the workforce.⁸⁷

83. *Id.* at 52.

84. The proportion among poor women is twice as high. Rates are also higher for Hispanics, the uneducated, those working in service occupations, or those in their early twenties. In addition, women who are Black, unmarried, adolescents, or unemployed are likely to have no insurance coverage at all. BLESSED EVENTS, *supra* note 43, at 43.

85. SOUTHERN CORPORATE COALITION TO IMPROVE MATERNAL AND CHILD HEALTH, BOARDROOMS AND BABIES: THE CRITICAL CONNECTION 5 (Apr. 1987) [hereinafter BOARDROOMS AND BABIES].

86. NATIONAL COMMISSION TO PREVENT INFANT MORTALITY, THE PRIVATE SECTOR'S ROLE IN REDUCING INFANT MORTALITY 2-3 (Apr. 1988) [hereinafter PRIVATE SECTOR'S ROLE]. For more information about the National Commission to Prevent Infant Mortality, see *supra* note 1.

87. *Id.*

Thus, policymakers must be concerned with the new and differing needs of a predominantly female working population. The nation's current policies toward fringe benefits, leave time away from work, and welfare are still designed for a society in which men work and women stay at home. Furthermore, our population is growing slower than at any time since the 1930's. As a result, there will be fewer young workers entering the labor force. A smaller population from which to choose new employees makes the promotion of healthy births and newborns even more crucial for the future of the United States.⁸⁸

In addition to the demographic changes just mentioned, economic trends will also affect the nation's businesses. According to the United States Labor Department, manufacturing will make up a much smaller share of our economy in the year 2000 than it does today.⁸⁹ New jobs will be created mostly in the service industries, which will require a higher level of education than the jobs of today.⁹⁰ Because children's ability to learn is directly connected to their health and development, and because the nation's workforce will need better educated applicants, healthy births should be a primary focus of our society, particularly our business leaders and boardroom policy-makers.⁹¹

Society pays the costs of uninsured or under-insured mothers and newborns who require expensive hospital care. Because the South has more poor people per capita, it bears a greater share of the uncompensated care burden. Studies have shown that while hospitals in the South have thirty-seven percent of the nation's beds, they provide fifty percent of the nation's charity care and account for forty percent of the nation's bad debt for health services.⁹² When uninsured pregnant women go to hospitals to have their babies, hospitals are often left with large uncollectible bills. These losses are shifted to paying

88. *Id.*

89. *Id.*

90. Most employees will need to be able to read, follow directions, and perform mathematics. Thirty percent of these service industry jobs will require a college degree. *Id.* at 3.

91. BOARDROOMS AND BABIES, *supra* note 85, at 6-7. Many societal problems, such as child abuse, learning disabilities, poverty, illiteracy, and teenage pregnancy can be linked to a poor start in life. The Washington Business Group on Health, during testimony before the National Commission to Prevent Infant Mortality, pointed out that when statistics for infant mortality, child care problems, youth suicide, school dropouts, and substance abuse are combined, the results indicate that our future generation is more likely to 1) consume vast public resources, 2) not pay taxes, 3) greatly reduce the productivity of their working parents, 4) not join the labor force, 5) not adapt to the computer driven information age, 6) not vote or produce leaders, and 7) produce more children with the same future. PRIVATE SECTOR'S ROLE, *supra* note 86, at 6.

92. BOARDROOMS AND BABIES, *supra* note 85, at 6-7.

patients through higher prices, higher taxes, and higher insurance rates, increasing the overall costs of health care and insurance for the private sector.⁹³

Given the proven effectiveness of prenatal care in reducing bad birth outcomes and the high costs of hospital care, business leaders are becoming increasingly aware that it makes good business sense to invest in preventive health approaches such as prenatal care. Of special concern to these business leaders is the fact that the majority of uninsured individuals in this country are employed or are spouses or dependents of employed persons. Business persons are, therefore, key factors in finding solutions to the problems of providing health insurance.⁹⁴

Most private health insurance is obtained as a fringe benefit of employment. As a result, insurance costs are an important factor which employers must consider when compensating employees. Unfortunately, health insurance benefits vary widely in the range of services provided, in the extent of reimbursement, and in the various exclusionary provisions such as those which limit benefits to specific providers or time periods. Ideally, companies should provide comprehensive insurance plans designed to promote maternal and child health. These plans should include prenatal care, delivery services, post-delivery care, neonatal intensive care, and well-child care coverage. There should also be incentives built into insurance packages which encourage women to take part in preventive health care services like prenatal health care.⁹⁵

Corporate policies which support the family can reduce stress, absenteeism, worker turnover, and unemployment, and can increase productivity. Therefore, leave policies, job protection, and child care arrangements should address women who might become pregnant during their employment.

Southern Bell Corporation is a good example of a corporation implementing comprehensive maternal and child health policies. At Southern Bell, a pregnant employee may take an unpaid leave within six months of her projected delivery date. During that time, the company monitors the care provided by her doctor. If the employee chooses to work up until her delivery date, she may use company clinics, staffed by registered nurses who monitor the woman's progress and offer advice. After the woman gives birth, she may take additional unpaid leave for another six months. There is also a wellness

93. INFANT MORTALITY, *supra* note 4, at 7.

94. PRIVATE SECTOR'S ROLE, *supra* note 86, at 5.

95. BOARDROOMS AND BABIES, *supra* note 85, at 11.

program, designed to assure quality, cost-effective medical care, including various prenatal and postnatal services.⁹⁶

V. PROGRAM INITIATIVES IN FLORIDA

Publicly-funded maternity care in Florida began in 1966, with the federally-funded Maternity and Infant Care Projects.⁹⁷ The State received funding for five such projects in seventeen counties. In 1977, the federal government awarded the State additional funds in order to establish new programs to further reduce poor pregnancy outcomes and their causes. In January 1978, Florida started the Improved Pregnancy Project in five counties in South Florida. By 1986, this program existed in every county in the State.⁹⁸

Today, the Improved Pregnancy Outcome (IPO) program is Florida's primary initiative for addressing the problems of low birthweight and poor pregnancy outcomes. The purpose of IPO is to "reduce maternal, fetal, and infant morbidity and mortality through increased accessibility to prenatal, delivery, and postpartum services to financially indigent pregnant women and their infants."⁹⁹

People eligible for IPO usually have incomes below 150% of the federal poverty level, do not qualify for Medicaid, and have little or no insurance coverage. Thus, IPO participants could not otherwise afford prenatal health care and hospitalization for delivery. Funding for the program comes solely from the State's general revenue fund. These monies, however, are combined with federal maternal and child health funds to provide a coordinated system of health care. IPO appropriations have grown substantially, from \$1.8 million in 1982-1983 to \$10 million in 1988-1989.¹⁰⁰ The creation of IPO programs in each of Florida's sixty-seven counties and the provision of State general revenue funds to support these programs is a significant achievement in Florida.

IPO utilizes a variety of providers, including public health nurses and physicians, certified nurse midwives, private physicians, hospitals, and other local agencies. The program also provides other services including patient education, counseling, and laboratory services. If needed, the patients are referred to other public programs like WIC, family planning services, and well-child clinics. In addition, county public health units are responsible for organizing and delivering ma-

96. PRIVATE SECTOR'S ROLE, *supra* note 86, at 8.

97. IMPROVING PREGNANCY, *supra* note 51, at 3.

98. FLA. ADMIN. CODE R. 10D-99.002(12).

99. *Id.* at 2.

100. *Id.* at 3.

ternity services in most areas of Florida. Thus, if possible, local resources are used to supplement IPO staffing and funding.¹⁰¹

In 1984, Florida implemented another program as part of the services offered through IPO. The Preterm Birth Prevention Program allows for a wide range of health professionals, including advanced registered nurses and certified nurse midwives, to identify women who have a high risk of delivering preterm babies. In addition, the nurses and obstetricians train these women to self-detect the signs of a preterm birth so that labor-inhibiting drugs may be effectively prescribed.¹⁰²

A. *Palm Beach County*

Palm Beach County is one example of a community rallying together to battle the problem of access to prenatal care for pregnant women. Maternity services in Palm Beach County are offered at five health department sites.¹⁰³ Patients not qualifying for the Medicaid program may qualify for County Human Services, which reach women with incomes up to 150% of the federal poverty level. There is also a private physician group in West Palm Beach providing services on a sliding fee scale, as well as a Planned Parenthood Clinic serving maternity patients at a reduced fee.

Some of the health department sites utilize nurse midwives to deliver care, while others utilize physicians. The actual delivery of infants takes place at three hospitals that are geographically distributed throughout the county. The health departments, through a system of contracts, provide payments to participating physicians as well as inpatient facilities. Through local funding, health departments are also able to supplement State funds in order to fill reimbursement gaps. As a result, the number of women delivering babies with no prenatal care in Palm Beach County has been reduced to half of its previous level.¹⁰⁴

B. *Tri-County Community Medical Program*

The Tri-County Community Medical Center Program (TCCMC) has been established in Madison, Jefferson, and Taylor Counties, and it provides, among other things, affordable and comprehensive maternity care to pregnant women through the use of certified nurse mid-

101. *Id.* at 3-4.

102. *Id.* at 4.

103. The five sites are located in Riviera Beach, Jupiter, Belle Glade, Lake Worth, and Delray Beach. *Id.* at 29.

104. *Id.*

wives. The TCCMC offers services to medically high-risk as well as low-risk women and is staffed with help from the local health departments. In addition, TCCMC is a subcontractor for the IPO and family planning services in the three counties, and it receives additional funding through the federally funded rural health clinic, located in Madison.¹⁰⁵

Although priority is given to women who cannot afford the care given by private practitioners, all women may receive maternity services through TCCMC. Sliding scale fees are assessed for women who exceed 150% of the federal poverty standard. However, in counties where TCCMC is the subcontractor for IPO services, IPO funds also finance care for women with incomes between 100% and 150% of the federal poverty level.¹⁰⁶

VI. RECOMMENDED COURSES OF ACTION

There is no doubt that early and continuous prenatal health care will save lives. Using medical technology in order to sustain tiny infants is not the answer to the nationwide problem of low birthweight babies. Clearly, the key to a healthier America lies in prevention because prevention costs less and is more effective than sustaining ill newborns on life-supporting equipment. Because practitioners are able to identify high-risk women, programs should target these women and provide the health care they need. Although there are a few such programs in place in Florida and across the nation, to be truly effective such programs must be more numerous and comprehensive.

The growing public concern associated with the United States' high infant mortality rate moved Congress in 1986 to create the National Commission to Prevent Infant Mortality (the "Commission"), headed by Florida Senator Lawton Chiles.¹⁰⁷ Two broad courses of action were outlined in the Commission's 1988 Report:

FIRST, we must provide *universal access* to early maternity and pediatric care for all mothers and infants. The existing financial, administrative, logistical, geographical, educational, and social barriers to essential health services for pregnant women and infants must be eliminated. Employers must make available health insurance coverage that includes maternity and well-baby care. Government must assume responsibility for those who lack private insurance or are unable to pay.

105. *Id.* at 41, 42.

106. *Id.* at 42.

107. Dem., United States Senate, 1971-1988; Governor of Florida, 1991-_____. For more information on the National Commission to Prevent Infant Mortality, see *supra* note 1.

SECOND, we must initiate immediately a sustained broad based effort to make the health and well-being of mothers and infants a national priority and give them the public attention and resources they deserve.¹⁰⁸

The bottom line obstacle to reaching these goals is financing. Consequently, the Commission recognized that in order to implement these goals it would be necessary for all areas of the private and public sectors to contribute, not only funds, but also time and effort. Specifically, federal, state, and local governments, as well as businesses, community organizations, and health care communities must assume responsibility and take action to improve problem birth outcomes.¹⁰⁹

As a plan of action, the Commission recommended, among other things, expanding the Medicaid Program to cover all pregnant women and infants with family incomes at or below 200% of the federal poverty level; making maternity and well-baby care available for employees, their spouses, and dependents through employment-based health insurance plans; allowing tax deductions for the full cost of health insurance for self-employed individuals and unincorporated businesses; and making women aware of available services as soon as they become pregnant.¹¹⁰ By utilizing these approaches and expanding the programs discussed earlier, previously high-risk babies will have a better chance not only for survival, but also for a more productive life.

VII. CONCLUSION

While the reasons for saving the lives of infants and their mothers are self-evident morally and economically, the question remains of how far American society is willing to go in helping to prevent these losses. The necessary revamping of our health care system touches the innate fear among politicians of raising taxes and the American public's distaste for new taxes. The fact remains, however, that with each infant death the future of the United States of America as a strong and growing nation is placed at risk. As the Commission aptly pointed out, the American public is "willing to spend an unlimited amount of money to keep low birthweight babies alive once they are born, but . . . [is] strangely reluctant to spend far less on the front-end preventive care that would make heroic, glamorous, and expensive efforts to save young lives unnecessary."¹¹¹ Today's children are the United

108. DEATH BEFORE LIFE, *supra* note 2, at 12.

109. *Id.*

110. *Id.* at 18-20.

111. *Id.* at 15.

States' most precious resource, and they are being carelessly and needlessly squandered. They must be protected, because they are today's solution to the future's loss.

